DeltaCare®
Administered by Delta Dental of Washington

DeltaCare Charter Plan

Snohomish County Employees

Delta Dental of Washington

Plan No. **00114**

Effective: **April 1, 2015**

Questions Regarding Your Plan

If you have questions regarding your dental benefits plan, you may call:

Delta Dental of Washington Customer Service

1-800-650-1583

Written inquiries may be sent to:

Delta Dental of Washington
Customer Service Department
P.O. Box 75983
Seattle, WA 98175-0983

You can also reach us by e-mail at *info@DeltaDentalWA.com.*

For the most current listing of Delta Dental participating dentists, visit our online directory at www.DeltaDentalWA.com or by calling us at 1-800-650-1583.

Communication Access for Individuals who are Deaf, Hard of Hearing, Deaf-blind or Speech-disabled

Communications with Delta Dental of Washington for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with Delta Dental of Washington through specially trained communications assistants.

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) *or* 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial Delta Dental of Washington Customer Service at 1-800-650-1583. The communications assistant will then relay the conversation between you and the Delta Dental of Washington customer service representative.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

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This booklet sets forth in summary form an explanation of the coverage available under your dental plan.

Introduction

Welcome to the DeltaCare® Plan, which is administered by Delta Dental of Washington (DDWA. DDWA is a member of the nationwide Delta Dental Plans Association. This benefit booklet is your Certificate of Coverage and sets forth, in summary form, an explanation of the coverage available under your dental plan.

How to Use Your Plan

The best way to take full advantage of your dental benefits plan is to understand its features. You can do this most easily by reading this benefit booklet *before* you go to your Primary Care Provider. This benefit booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this benefit booklet does not answer all of your questions, or if you do not understand something, call a DDWA customer service representative 1-800-650-1583. *Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.*

Choosing a Primary Care Dentist (PCP)

When you enroll in the DeltaCare Dental Plan, you must complete the enrollment information and may indicate your dental office choices at that time. New enrollees have 60 days to select and notify us of your preferred Primary Care Provider (PCP). A PCP is a Washington state General Practitioner that has chosen to participate in the DeltaCare Network.

If you do not select a PCP within 60 days, we will assign you to a provider near your home. The choice of PCP can be changed with proper notice to DDWA, but participation in the plan must continue at least until the next open enrollment period. Please contact us at 1-800-650-1583 for more information on selecting or changing your PCP or to notify us of your selection.

Your selected dental office is now the center for all of your dental needs. The PCP will perform most dental services. For specialty care, the PCP may elect to refer treatment to a DeltaCare Dental Plan Specialist.

After you have enrolled, you will receive a membership card and letter. The letter will include the address and telephone number of your PCP.

If your PCPs participation in the DeltaCare Network is terminated, you will receive written notification.. This notification will explain your option to: 1) automatically be assigned to another PCP; or 2) select another PCP from the directory of open PCPs. If your PCP is to be absent for an extended period of time, you may transfer to another PCP dentist during the period of the absence.

Appointments

To receive dental care, simply call your primary care dental office to make an appointment. Routine, non-emergency appointments will be scheduled within 3 weeks of the date of the request. Dental services which are not performed by the assigned DeltaCare Dental Plan office or properly referred to a DeltaCare Dental Plan Specialist will not be covered by the DeltaCare Dental Plan.

Specialty Services

Your PCP is responsible for coordinating all specialty care and will either perform the specialty treatment or refer you to a DeltaCare Network Specialist. In some unique cases the PCP may refer you to a non-DeltaCare Network Specialist, but prior authorization from DDWA is required.

Urgent Care

Your PCP shall provide urgent dental care for a covered procedure within 24 hours of being contacted. If an Enrollee requires urgent dental care and is not able to be seen by their PCP within 24 hours or is not within a reasonable distance of their PCP's office, the enrollee may receive treatment from another dentist. Such treatment is limited to the treatment that is necessary to evaluate and stabilize the enrollee until they can obtain further treatment from their assigned dentist.

The Plan shall reimburse the Enrollee for the cost of such urgent dental care which exceeds the enrollee's Co-payment up to a $100 maximum per calendar year. In cases where immediate additional care beyond stabilization and palliative treatment is medically required, DDWA will carefully review and consider additional reimbursable coverage beyond the $100 maximum according to the standard list of covered benefits under the plan.

Emergency Care

DeltaCare Network dentists have made provisions for delivering emergency care. Emergency care is available 24 hours a day, every day of the year. Treatment of a dental emergency, those rare dental health instances that may be life threatening or cause severe bodily injury, shall not require a predetermination if a prudent layperson acting reasonably would believe that such an emergency condition exists. The Plan would encourage the enrollee to seek a preauthorization from the Plan for such emergency care if at all practical, but would not require preauthorization if the treatment is a listed procedure under the terms of coverage. You should notify DeltaCare after receiving emergency dental care within 15 days, or when practical, as to the extent of such emergency dental treatment.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this plan, the benefit period is the 12-month period starting the first day of the calendar month, April 1, and ending the last day of the calendar month, March 31.

Employee Eligibility, Enrollment and Termination

Enrolled Employees are all full-time Eligible Employees who have completed the enrollment process and for whom employer contributions are made.

New employees are eligible on the first day of the month following completion of the waiting period established by the employer, and become enrolled when they have completed the enrollment process.

You must complete the enrollment process in order to receive benefits. DDWA must receive completed enrollment information within 60 days of employee's Eligibility Date. If the enrollment information is not received within 60 days, enrollment will not be accepted until the next Open Enrollment Period.

Eligibility and Coverage terminates at the end of the month in which you cease to be an employee, or at the end of the month for which a timely payment of monthly Premiums was made by Group on your behalf to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

In the event of a suspension or termination of compensation directly or indirectly as a result of a strike, lockout, or other labor dispute, an Enrolled Employee may remain enrolled by paying the applicable Premium directly to the employer for a period not to exceed six months. Payment of Premiums must be made when due, or DDWA may terminate the coverage.

The Federal Family and Medical Leave Act ("FMLA") became effective August 5, 1993. The benefits for an enrolled member under this DDWA dental plan may be continued provided the employee is eligible for FMLA and is on a leave of absence that meets the FMLA criteria. For further information, contact your employer.

You may change or terminate plan coverage only during an open enrollment period, except as specified under the *Special Enrollment Periods* section below.

You may change plans (i.e. a DeltaCare Plan to a non-DeltaCare plan offered by your employer) only at a renewal or extension of the contract. In the event that an Employee moves and there is not a PCP within 30 miles of their new address, then you may change to the non-DeltaCare plan by contacting the Benefit Manager/Coordinator or Human Resource Department of your employer.

Dependent Eligibility, Enrollment and Termination

Eligible Dependents are your spouse or state registered domestic partner and children of yours, your spouse or your domestic partner, from birth through age 25. Children include biological children, stepchildren, foster children and adopted children. A dependent's spouse and/or child(ren) are not eligible for coverage under this plan.

Non state-registered domestic partnership is a relationship whereby two people:

a) Share the same regular and permanent residence;
b) Have a close personal committed relationship;
c) Are jointly responsible for "basic living expenses" such as food, shelter and similar expenses;
d) Are not married to anyone;
e) Are each 18 years of age or older;
f) Are not related by blood closer than would bar marriage in their state of residence;
g) Were mentally competent to consent to contract when the domestic partnership began; and
h) Are each other's sole domestic partner and are responsible for each other's common welfare.

Eligible Dependents may not enroll in this Plan unless the employee is an Enrolled Employee.

A child will be considered an eligible dependent as an adopted child if one of the following conditions are met: 1) the child has been placed with the enrolled employee for the purpose of adoption under the laws of the state in which the employee resides; or 2) the employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see *"Special Enrollment"*).

Coverage for a dependent child over the limiting age will not be terminated if the child is and continues to be both 1) incapable of self-sustaining employment by reasons of developmental disability (including mental retardation, cerebral palsy, epilepsy, autism, or another neurological condition closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals) or physical handicap and 2) chiefly dependent upon the eligible person for support and maintenance, provided proof of incapacity and dependency is furnished to DDWA within 31 days of the child's attainment of the limiting age and the child was an eligible dependent upon attainment of the limiting age. DDWA reserves the right to periodically verify the disability and dependency but not more frequently than annually after the first two years.

Pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), the Plan also provides coverage for a child, even if the parent does not have legal custody of the child or the child is not dependent on the parent for support. This applies regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If parent is not enrolled in dental benefits, he/she must enroll for coverage for himself/herself and the child. If the Plan receives a valid QMCSO and the parent does not enroll the dependent child, the custodial parent or state agency may do so.

A QMCSO may be either a National Medical Child Support Notice issued by a state child support agency or an order or judgment from a state court or administrative body directing the company to cover a child under the plan. Federal law provides that a QMCSO must meet certain form and content requirements to be valid. A custodial parent, a state agency or an alternate recipient may enroll a dependent child under the terms of a valid QMCSO. A child who is eligible for coverage through a QMCSO may not enroll dependents for coverage under the plan.

Unless otherwise indicated, an Eligible Dependent shall cease to be eligible to enroll in this Plan at the end of the calendar month during which the employee ceases to be an Eligible Employee, or the person no longer meets the definition of an Eligible Dependent, whichever occurs first.

Unless otherwise indicated, an Enrolled Dependent shall cease to be enrolled at the end of the calendar month in which the Enrolled Employee ceases to be enrolled, or the end of the calendar month for which Group has made timely payment of the monthly Premiums on behalf of the Enrolled Employee to DDWA, or upon termination of Group's Contract with DDWA, whichever occurs first.

You may terminate coverage of an enrolled dependent only during a subsequent renewal or extension of the dental plan. Once an enrolled employee terminates such dependents coverage, the coverage cannot be reinstated, unless there is a change in family status.

A new family member, with the exception of newborns and adopted children, should be enrolled on the first day of the month following the date he or she qualifies as an eligible dependent (see "Special Enrollment").

A newborn shall be covered from and after the moment of birth, and an adopted child shall be covered from the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. A foster child is covered from the time of placement. When additional Premium is not required, we encourage enrollment as soon as possible to prevent delays in claims processing (see "Special Enrollment") but coverage will be provided in any event. Dental coverage provided shall include, but is not limited to, coverage for congenital anomalies of infant children.

Enrolled employees who choose not to enroll an eligible dependent during the initial enrollment period of the dental plan may enroll the eligible dependent only during an open enrollment, except under special enrollment.

Special Enrollment Periods

Special enrollments are allowed under the following conditions:

1. **Loss of Other Coverage**

   If you and/or your eligible dependents involuntarily lose coverage under another dental plan, you may apply for coverage under this Plan if the following applies:

   - You declined enrollment in this Plan.
   - You lose eligibility in another health plan or your coverage is terminated due to the following:
     - Legal separation or divorce
     - Cessation of dependent status
     - Death of Employee
     - Termination of employment or employer contributions
     - Reduction in hours
     - Loss of individual or group market coverage because of move from plan area or termination of benefit plan
     - Exhaustion of COBRA coverage
   - Your application to enroll in this Plan is received by DDWA within 31 days of losing other coverage. Coverage will be effective the first day of the month following receipt of application.

   If these conditions are not met, you must wait until the next Open Enrollment Period to apply for coverage.

   Note: Eligible dependents may not enroll in this Plan unless the Employee is a Subscriber.

2. **Marriage, Birth or Adoption**

If you declined enrollment in this Plan, you may apply for coverage for yourself and your eligible dependents in the event of marriage, birth of a child(ren), or when you or your spouse assume legal obligation for total or partial support or upon placement of a child(ren) in anticipation of adoption.

- Marriage or Domestic Partner Registration — DDWA requests the application for coverage be made within 31 days of the date of marriage/registration. If enrollment and payment are not completed within the 31 days, the eligible dependent may be enrolled during the next open enrollment.

  DDWA considers the terms spouse, marriage, marital, husband, wife, widow, widower, next of kin and family to apply equally to domestic partnerships or individuals in domestic partnerships, as well as to marital relationships and married persons. References to dissolution of marriage will apply equally to domestic partnerships that have been terminated, dissolved or invalidated. Where necessary, gender-specific terms such as husband and wife used in any part of this benefit booklet will be considered as gender neutral and applicable to individuals in domestic partnerships. DDWA and the group will follow all applicable state and federal requirements, including any applicable regulations.

- Birth — A newborn shall be covered from and after the moment of birth. DDWA requests the application for coverage be made within 90 days of the date of birth. Enrollment may be completed at any time up to the fourth birthday. If enrollment is not completed within the 90 days, the enrollment becomes effective on the first day of the month in which enrollment occurs. Enrollment after the fourth birthday must be coincident with an Open Enrollment period.

- Adoption — DDWA requests the application for coverage be made within 90 days of the date of assumption of a legal obligation for total or partial support or upon placement of the child in anticipation of adoption. If an additional premium for coverage is required and enrollment and payment is not completed within the 90 days, the eligible dependent may be enrolled during the next open enrollment.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

Extension of Benefits

In the event a person ceases to be eligible, or in the event of termination of this Plan, DDWA shall not be required to pay for services beyond the termination date. The exception will be for the completion (within three weeks) of procedures requiring multiple visits to complete the work started while coverage was in effect and that are otherwise benefits under the terms of this Plan.

How to Report Suspicion of Fraud

If you suspect a dental provider, an insurance producer or individual may be committing insurance fraud, please contact the DDWA hotline for Fraud & Abuse at (800) 554-1907. You may also want to alert any of the appropriate law enforcement authorities listed:

- The National Insurance Crime Bureau (NICB). You can reach the NICB at (800) 835-6422 (callers do not have to disclose their names when reporting fraud to the NICB).
- The Office of the Insurance Commissioner (OIC) at (360) 725-7263 or go to www.insurance.wa.gov for more information.

Health Insurance Portability and Accountability Act (HIPAA)

Delta Dental of Washington is committed to protecting the privacy of your dental health information.

The Health Insurance Portability and Accountability Act (HIPAA) requires DDWA to alert you of the availability of our Notice of Privacy Practices (NPP), which you may view and print by visiting www.deltadentalwa.com. You may also request a printed copy by calling the DDWA privacy hotline at (800) 554-1907.

Children's Health Insurance Plan Reauthorization Act (CHIPRA)

CHIPRA allows special enrollment rights and allows states to subsidize premiums for employer-provided group health coverage for eligible children (excluding benefits provided under health FSAs and high-deductible health plans).

- Employees and dependents that are eligible but not enrolled for coverage may enroll under the following conditions:
- An employee or dependent loses Medicaid or CHIP coverage due to loss of eligibility, and the employee requests coverage within 60 days after the loss of that coverage.
- An employee or dependent becomes eligible for a premium assistance subsidy under Medicaid of CHIP and the employee requests coverage within 60 days after the change in eligibility for subsidy.

Contact your employer for further clarification and details of how they plan to implement this coverage for eligible persons.

Uniformed Services Employment & Re-Employment Rights Act (USERRA)

Employees called to military service have the right to continue dental coverage for up to 24 months by paying the monthly premiums, even if they are employed by groups that are too small to comply with COBRA. USERRA contains other employment-related requirements, including (but not limited to) the employer having to hold the employee's position until he/she returns from service. For further information on this act, please contact your legal counsel or insurance producer.

Conversion Option

If your dental coverage stops because your employment or eligibility ends or the group policy ends, you may apply directly to DDWA to convert your coverage to an individual policy. You must apply within 31 days after termination of your group coverage. The benefits and premium costs may be different from those available under your current plan. There may be a gap in coverage between the date your coverage under your current plan ends and the date that coverage begins under an individual policy.

You may apply for coverage under a DDWA Individual Plan online at www.DeltaDentalWA.com/Individual or by calling (800) 286-1885 to have an application sent to you. Converted policies are subject to certain benefits and limits.

Benefits Covered By Your Plan

The following are the covered dental benefits under this Plan and are subject to the limitations and exclusions contained in this benefit booklet. Such benefits (as defined) are available only when provided by a licensed dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

Note: Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.

Diagnostic

Covered Dental Benefits

- Diagnostic evaluation for routine or emergency purposes
- X-rays (radiographic images)

Limitations

- Routine evaluation is covered twice in a Benefit Period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is as periodic oral evaluation.
- Limited problem-focused evaluations are covered twice in a Benefit Period.
- Full mouth or panoramic x-ray is limited to one every 3 years and for patients over 3 years of age.
- Bitewing x-rays limited to not more than twice in a Benefit Period.

Preventive

Covered Dental Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Sealants
- Topical application of fluoride including fluoridated varnishes
- Space maintainers
- Preventive resin restoration

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period. Additional periodontal maintenance procedures are the patient's responsibility;
    - Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Topical application of fluoride is limited to two covered procedures in a benefit period.
- Space maintainers are covered for children through the age of 13.
- Sealants:
    - Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
    - The application of a sealant is a covered dental benefit once in a two-year period per tooth from the date of service.

- Preventive resin restorations:
  - Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface.
  - The application of a preventive resin restoration is a covered dental benefit once in a two-year period per tooth from the date of service.
  - The application of preventive resin restoration is not a paid covered benefit for two years after a sealant or preventive resin restoration on the same tooth from the date of service.

Restorative

Covered Dental Benefits

- Restorations (fillings)
- Stainless steel crowns

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period;
- Crowns are covered once in a five-year period for patients 16 years of age or older.
- Core build-up, including pins is covered once in a 2 year period.
- Stainless steel crowns on primary teeth are covered once in a two-year period.
- Resin-based composite crowns on anterior teeth are covered once in a two year period.

Periodontics

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Services covered include
  - Periodontal scaling/root planing
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or fewer)
  - Localized delivery of antimicrobial agents
  - Gingivectomy

Limitations

- Root planing/subgingival curettage is covered once in a 12-month period.
- Limited occlusal adjustments are covered once in a 12-month period.
- Localized delivery of antimicrobial agents approved by DDWA is limited to two teeth per quadrant, twice per Benefit Period under certain conditions of oral health when performed at the suggested regimen for that therapy.
- Periodontal surgery is covered once in a three-year period.
- Two sites of soft tissue grafting are covered in the same quadrant in a three year period.
- Scaling and root planning must be done a minimum of six weeks and a maximum of six months prior to periodontal surgery or localized delivery of antimicrobial agents.
- One Periodontal Maintenance therapy treatment, specifically periodontal prophylaxis, is covered twice in a Benefit Period and is to be charged at the applicable co-payment level. The cost of additional Periodontal Maintenance prophylaxis treatments over twice in a Benefit Period are your responsibility.
- Full mouth debridement is covered once in a three-year period.
- Crown lengthening - hard/soft tissue is covered once in a three year period.

Endodontics

Covered Dental Benefits

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period.
- Pulp Vitality Tests are limited to 1 per visit, including multiple teeth.

Prosthodontics

Covered Dental Benefits

- Dentures
- Fixed partial dentures (fixed bridges)
- Adjustment or repair of an existing prosthetic appliance

Limitations

- Full upper and/or lower dentures and partial upper and/or lower dentures are not to exceed one each in any five-year period and only then if it is unserviceable and cannot be made serviceable.
- Rebase of full upper and/or lower dentures and partial upper and/or lower dentures are not to exceed one each in a 12 month period following initial placement.
- Denture relines are limited to one per denture during any 12 consecutive months except in the case of an immediate denture then a reline is a benefit six months after the initial placement.
- Fixed partial denture is covered to replace one missing, anterior tooth. Fixed partial denture to replace multiple missing anterior teeth and/or any number of posterior teeth is covered at the cost of a partial denture.
- Upper Tissue Conditioning is limited to twice per 3 year period.

Note*: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered dental benefit. A predetermination is not a guarantee of payment.*

Managed Care Orthodontic Limitations and Exclusions

Orthodontic Limitations

This plan provides coverage for orthodontic treatment plans provided through DeltaCare panel orthodontists. The cost to the patient for the treatment plan are listed in the Schedule of Benefits and Co-payments subject to the following:

- Orthodontic treatment must be provided by a DeltaCare orthodontist.
- Plan benefits cover 24 months of active comprehensive orthodontic treatment. They include initial examination, diagnosis, consultation, initial banding, 24 months of active treatment, de-banding and the retention phase of treatment. The retention phase includes the initial construction, placement and adjustments to retainers and office visits for a maximum of two years.
- For treatment plans extending beyond 24 months of active treatment, the patient will be subject to a monthly office visit fee not to exceed $75.00 per month, not to exceed an additional 12 months up to a maximum of 36 months from start to finish.

- Should a patient's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the patient and not DeltaCare will be responsible for payment of balance due for treatment provided after cancellation or termination. In such a case the patient's payment shall be based on the provider's Maximum Allowable Fee at the beginning of treatment. The amount will be pro-rated over the number of months to completion of the treatment and, will be payable by the patient on such terms and conditions as are arranged between the patient and the orthodontist.
- If treatment is not required or the patient chooses not to start treatment after the diagnosis and consultation have been completed by the orthodontist, the patient will be charged a consultation fee of $25.00 in addition to diagnostic record fees.
- Three re-cementations or replacements of a bracket/band on the same tooth or a total of five rebracketings/rebandings on different teeth during the covered course of treatment are a benefit. If any additional re-cementations or replacements of brackets/bands are performed, the patient is responsible for the cost at the dentist's DDWA filed fee for the covered benefit.
- Comprehensive orthodontic treatment (Phase II) consists of repositioning all or nearly all of the permanent teeth in an effort to make the patient's occlusion as ideal as possible. This treatment usually requires complete fixed appliances; however, when the DeltaCare orthodontist deems it suitable, removable appliance therapy may be substituted at the same coinsurance amount as for fixed appliances.

Orthodontic Exclusions

- Lost, stolen or broken orthodontic appliances, functional appliances, headgear, retainers and expansion appliances;
- Retreatment of orthodontic cases;
- Changes in treatment necessitated by accident of any kind, and/or lack of patient cooperation;
- Surgical procedures incidental to orthodontic treatment;
- Myofunctional therapy;
- Surgical procedures related to cleft palate, micrognathia, or macrognathia;
- Treatment related to temporomandibular joint disturbances;
- Supplemental appliances not routinely utilized in typical Phase II orthodontics;
- Active treatment that extends more than 24 months from the point of banding dentition will be subject to an office visit charge not to exceed $75.00 per month;
- Restorative work caused by orthodontic treatment;
- Phase I orthodontics is an exclusion as well as activator appliances and minor treatment for tooth guidance and/or arch expansion;
- Extractions solely for the purpose of orthodontics;
- Treatment in progress at inception of eligibility;
- Transfer after banding has been initiated;
- Composite bands and lingual adaptation of orthodontic bands are considered optional treatment and would be subject to additional charges.

Phase I is defined as early treatment including interceptive orthodontia prior to the development of late mixed dentition.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, DDWA prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the subsequent payment of benefits, subsequent payment is not covered.

General Dental Exclusions

1. General anesthesia, including intravenous and inhalation sedation, and the services of a special anesthesiologist except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures;
2. Cosmetic dental care. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching;
3. Services for injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, and services which are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act;
4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion; such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth;
5. Application of desensitizing agents;
6. Experimental services or supplies, which include:
   a. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
      i) The services are in general use in the dental community in the state of Washington;
      ii) The services are under continued scientific testing and research;
      iii) The services show a demonstrable benefit for a particular dental condition; and
      iv) They are proven to be safe and effective.

      Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
   b. Any denial of benefits by DDWA on the grounds that a given procedure is deemed experimental may be appealed to DDWA. DDWA will respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the eligible person.
   c. Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review under WAC 284-43-620(2).
7. Dental services performed in a hospital and related hospital fees;
8. Loss or theft of fixed or removable prosthetics (crowns, bridges, full or partial dentures);
9. Dental expenses incurred in connection with any dental procedure started after termination of eligibility of coverage;
10. Dental expenses incurred in connection with any dental procedure started prior to the enrollee's eligibility;
11. Cysts and malignancies;
12. Laboratory examination of tissue specimen;
13. Any drugs or medicines, even if they are prescribed. This includes analgesics (medications to relieve pain) and patient management drugs, such as pre-medication and nitrous oxide;
14. Accidental injury. This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage;

15. Accidental injury. Accidental injury is defined as damage to the hard and soft tissues of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) function will be covered at the normal schedule of benefits;
16. Cases which in the professional judgment of the attending dentist a satisfactory result cannot be obtained or where the prognosis is poor or guarded;
17. Prophylactic removal of impactions (asymptomatic, nonpathological);
18. Specialist consultations for non-covered benefits;
19. Implant placement or removal, appliance placed on or services associated with implants;
20. Orthodontic treatment which involves therapy for myofunctional problems, TMJ, dysfunctions, or hormonal imbalances causing growth and developmental abnormalities;
21. All other services not specifically included on the patient's Schedule of Benefits and Co-paymentse;
22. Treatment of fractures and dislocations to the jaw;
23. Dental services received from any dental office other than the assigned dental office, unless expressly authorized in writing by DDWA or as cited under the "*Emergency or Urgent Care*." Section.

Governing Administrative Policies

Unlike medical care where the diagnosis dictates more specifically the method of treatment to be rendered, in dental care, the dentist and patient frequently consider various treatment options.

The following guidelines are an integral part of the dental plan and are consistent with the principles of accepted dental practice and the continued maintenance of good dental health.

In all cases in which the patient selects a more expensive plan of treatment than is customarily provided, the more expensive treatment is considered optional. The patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the optional treatment plus any co-payment for covered benefits.

Failure to pay a scheduled co-payment at the time of service may prevent future dental services from being rendered. Emergency services that are required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions, which, if not immediately diagnoses and treated, would lead to disability and death are exempt from this denial of services.

Replacement of prosthetic appliances (crowns, bridges, partials and full dentures) shall be considered only if the existing appliance is no longer functional or cannot be made functional by repair or adjustment and meets the five year limitation for replacement.

Partial Dentures

1. A removable cast metal partial denture is considered an adequate restoration of a case when more than one tooth is missing in a dental arch. If the patient selects another course of treatment, the patient must pay the difference in cost between the dentists' DDWA filed fees for the covered benefit and the optional treatment, plus any co-payment for the standard benefit.
2. If a cast metal partial denture will restore the case, the PCP will apply the difference of the cost of such procedure toward any alternative treatments which the patient and dentist may choose to use. The patient must pay the difference in cost between the dentist's DDWA file fees for the covered benefit and the optional treatment plus any co-payment for the covered benefit.
3. An acrylic partial denture may be considered a standard benefit in cases involving extensive periodontal disease. Patients will pay the applicable co-payment for a cast metal partial denture.

Complete Dentures

1. If, in the construction of a denture, the patient and the PCP decide on personalized restorations or employ specialized techniques as opposed to standard procedures, the patient must pay the difference in cost between the dentists' DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.
2. Full upper and/or lower dentures are not to exceed one each in any five year period from initial placement. The patient is entitled to a new upper or lower denture only if the existing denture is more than five years old and cannot be made satisfactory by either reline or repair.

Fillings and Crowns

1. Crowns will be covered only if there is not enough retention and resistance form left in the tooth to hold a filling. For example, the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
2. Porcelain or porcelain fused to metal crowns on all first, second or third molars are considered optional treatment, base metal crowns are considered adequate restorations/ the standard benefit. If upgrades are performed, the patient must pay the difference in cost between the dentists' DDWA filed fees for the standard benefit and optional treatment, up to a maximum of $200 plus any co-payment for the covered benefit. The patient must be permitted the option of the base metal crown as a benefit if desired.
3. The DeltaCare plan provides amalgam (posterior) and resin-based (anterior) restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional, and if provided, the patient must pay the difference in cost between the dentist's DDWA file fees for the covered benefit and the optional treatment plus any co-payment for the covered benefit.
4. A restoration is a covered benefit only when required for restorative reasons (radiographic evidence of decay or missing tooth structure). Restorations placed for any other purposes including, but not limited to cosmetics, abrasion, erosion, restoring or altering vertical dimension, or the anticipation of future fractures, are not covered benefits.
5. Composite resin restorations in posterior teeth are considered optional treatment with the exception of the buccal surfaces of the bicuspids. If provided, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.
6. Anterior porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. An allowance will be made for an acrylic crown. If performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and optional treatment, plus any co-payment for the covered benefit.
7. A crown placed on a specific tooth is allowable only once in a five year period from initial placement.
8. A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required.

Fixed Partial Denture (Fixed Bridges)

1. A fixed partial denture to replace one (1) missing permanent anterior tooth is covered for patients 16 or older. Such treatment will be covered if the patient's oral health and general condition permits.
2. Fixed partial dentures for patients under the age of 16 are optional to a partial denture.
3. A fixed partial denture to replace more than one permanent anterior tooth or any number of permanent posterior teeth is optional to a removable partial denture. The patient must pay the difference in cost between the dentist's filed fee for the covered benefit (a removable partial denture) and the optional treatment (a fixed bridge), plus any co-payment for the covered benefit.

4. Fixed partial dentures are not a benefit when provided in connection with a partial denture on the same arch. A fixed bridge is not a covered benefit once a removable partial denture has been delivered in the same arch.
5. Replacement of an existing fixed partial denture (to replace one (1) missing permanent anterior tooth) is covered after five years from initial placement and only if it involves the same teeth as the prior fixed partial denture.

Reconstruction

1. The DeltaCare plan provides coverage for procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandiular joint (TMJ) are not covered benefits. Extensive treatment plans involving ten or more crowns or units of fixed bridgework are considered full mouth reconstructions and are not a benefit of the DeltaCare plan.

Specialized Techniques

1. Noble or titanium metal for removable appliances, crowns, precision abutments for partials or bridges (overlays, implants, and appliances associated therewith), personalization and characterization, are all considered optional treatment. If performed, the patient must pay the difference in cost between the dentist's DDWA filed fees for the covered benefit and the optional treatment, plus any co-payment for the covered benefit. (As long as the patient has the option of the benefit procedure.)

Preventative Control Programs

1. Soft tissue management programs are not covered. The periodontal pocket charting, root planing/scaling oral hygiene instruction and prophylaxis are covered benefits and, if performed as part of a soft tissue management program, will be provided for listed co-payments, if any. Irrigation, infusion, special tooth brush, etc., are considered optional treatment. If performed, the patient is responsible for the cost.
2. Follow-up examinations for reevaluation, particularly periodontal reevaluation, are considered to be part of the general serviced rendered.

Frenectomy

1. The frenum can be excised when the tongue has limited mobility; or there is a large diastema between anterior teeth; or when the frenum interferes with a prosthetic appliance.

Pedodontia

1. Pedodontic referrals must be preauthorized by DeltaCare. Benefits for dependent children through age three are covered at 100 percent of the agreed upon fee less any applicable co-payments for covered benefits and children four years and older are at 50 percent of agreed upon fee less any applicable co-payments for covered services.

Treatment Planning

1. The objective of this plan is to see that all patients are brought to a good level of oral health and that this level of oral health is maintained. To achieve these objectives takes treatment planning. Priorities have been established on the following basis:
    a) Priority attention is given to those procedures that, if not done first, could have an immediate effect on the patient's overall oral health.
    b) Priority is next given to work such as active dental decay and periodontal problems that would not have an immediate effect on the patient's oral health.
    c) Priority is given to replacement of missing teeth causing a gross lack of function.

d) Exceptions are made to this treatment-planning concept based on individual circumstances

Schedule of Benefits and Co-Payments

Please see the following table which describes the Benefits and Co-Payments for this Plan. The Benefits and Co-Payments listed below are Effective as of **January 1, 2015.**

Schedule of Benefits and Co-Payments

The services covered under the DeltaCare Dental Plan are listed in the following schedule. These co-payments are your total price, including lab work. All coverage is subject to the exclusions and limitations set forth in the benefit descriptions and exclusions.

Code	Description	Co-payment	Notes
	Diagnostic D0100 - D0999		
D0120	Periodic oral examination - established patient	0	
D0125	Failed Appointment without 24 hr notice per 15 min of appt time	10	
D0140	Limited oral evaluation-problem focused	0	R
D0145	Oral Evaluation - patient under age 3	0	
D0150	Comprehensive oral evaluation-new or established(inactive) patient	0	R
D0160	Detailed and extensive oral evaluation - Problem focused, by report	0	R
D0170	Re-evaluation-limited, problem focused (Established pt not post op visit)	0	R
D0180	Comprehensive Periodontal Exam	0	R
D0190	Screening of a patient	NB	
D0191	Assessment of a patient	NB	
D0210	Intraoral - complete series of radiographic images (including bitewings)	0	
D0220	Intraoral - periapical, first radiographic image	0	
D0230	Intraoral - periapical, each additional radiographic image	0	
D0240	Intraoral - occlusal radiographic image	0	
D0250	Extraoral – first radiographic image	NB	
D0260	Extraoral – each additional radiographic image	NB	
D0270	Bitewing - single radiographic image	0	
D0272	Bitewings - two radiographic images	0	
D0273	Bitewings - three radiographic images	0	
D0274	Bitewings - four radiographic images	0	
D0277	Vertical bitewings - 7 to 8 radiographic images	0	
D0330	Panoramic radiographic image	0	
D0394	Digital subtraction of two or more image or image volumes of the same modality	0	
D0395	Fusion of two or more 3D image volumes of one or more modalities	0	
D0415	Collection of microorganisms for culture and sensitivity	0	
D0425	Caries susceptibility test	0	
D0460	Pulp vitality tests	0	R
D0470	Diagnostic casts	0	
D0472	Accession of tissue, gross examinations, preparation and transmission of written report	0	

Code	Description	Co-payment	Notes
D0473	Accession of tissue, gross and microscopic examinations, preparation and transmission of written report	0	
D0474	Accession of tissue, gross and microscopic examinations, including assessment of surgical margins for presence of disease, preparation and transmission of written report	0	
D0601	Caries risk assessment and documentation, with a finding of low risk	0	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	0	
D0603	Caries risk assessment and documentation, with a finding of high risk	0	
	Preventive D1000 - D1999		
D1110	Prophylaxis cleaning- adult - 1 per 6 month period	0	
D1120	Prophylaxis cleaning- child - 1 per 6 month period	0	
D1206	Topical application of fluoride varnish	0	
D1208	Topical application of fluoride – excluding varnish	0	**covered through age 18*
D1310	Nutritional counseling for control of dental disease	0	
D1330	Oral hygiene instructions	0	
D1351	Sealant - per tooth	5	
D1352	Preventive resin restoration – per tooth	5	
D1353	Sealant repair – per tooth	5	
D1510	Space maintainer - fixed, unilateral	10	
D1515	Space maintainer - fixed, bilateral	10	
D1520	Space maintainer - removable, unilateral	10	
D1525	Space maintainer - removable, bilateral	10	
D1550	Re-cement or re-bond of space maintainer	0	
D1555	Removal of fixed space maintainer	0	
	Minor Restorative D2000 - D2335		
D2140	Amalgam - one surface, primary or permanent	0	
D2150	Amalgam - two surfaces, primary or permanent	0	
D2160	Amalgam - three surfaces, primary or permanent	0	
D2161	Amalgam - four or more surfaces, primary or permanent	0	
D2330	Resin-based composite - one surface, anterior	0	
D2331	Resin-based composite - two surfaces, anterior	0	
D2332	Resin-based composite - three surfaces, anterior	0	
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	0	
D2390	Resin-based composite crown, anterior	0	
D2391	Resin-based composite - one surface, posterior	45	
D2392	Resin-based composite -two surface, posterior	55	
D2393	Resin-based composite - three surface, posterior	65	
D2394	Resin-based composite - four or more surface, posterior	75	
	Major Restorative D2510-D2999		
D2510	Inlay - metallic - one surface	75	
D2520	Inlay - metallic - two surfaces	75	
D2530	Inlay - metallic - three surfaces	75	
D2542	Onlay- metallic- two surfaces	75	

Code	Description	Co-payment	Notes
D2543	Onlay - metallic - three surfaces	75	
D2544	Onlay metallic - four or more surfaces	75	
D2610	Inlay - porcelain/ceramic - one surface	135	
D2620	Inlay - porcelain/ceramic - two surface	150	
D2630	Inlay - porcelain/ceramic - three or more surfaces	160	
D2642	Onlay - porcelain/ceramic - two surfaces	150	
D2643	Onlay - porcelain/ceramic - three surfaces	165	
D2644	Onlay - porcelain/ceramic - four or more surfaces	175	
D2650	Inlay - resin-based composite - one surface	85	
D2651	Inlay - resin-based composite - two surfaces	95	
D2652	Inlay - resin-based composite - three or more surfaces	115	
D2662	Onlay - resin-based composite - one surface	110	
D2663	Onlay - resin-based composite - two surfaces	120	
D2664	Onlay - resin-based composite - three or more surfaces	145	
D2710	Crown - resin-based composite (indirect)	35	
D2712	Crown - 3/4 resin-based composite (indirect)	35	
D2720	Crown - resin with high noble metal	155	
D2721	Crown - resin with predominantly base metal	55	
D2722	Crown - resin with noble metal	95	
D2740	Crown - porcelain/ceramic substrate	195	
D2750	Crown - porcelain fused to high noble metal	195	
D2751	Crown - porcelain fused to predominantly base metal	95	
D2752	Crown - porcelain fused to noble metal	135	
D2780	Crown-3/4 cast high noble metal	170	
D2781	Crown-3/4 cast predominantly base metal	70	
D2782	Crown-3/4 cast noble metal	110	
D2783	Crown-3/4 porcelain/ceramic	195	
D2790	Crown - full cast high noble metal	170	
D2791	Crown - full cast predominantly base metal	70	
D2792	Crown - full cast noble metal	110	
D2794	Crown - titanium	195	
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage restoration	0	
D2915	Re-cement or re-bond indirectly prefabricated post and core	0	
D2920	Re-cement or re-bond crown	0	
D2921	Reattachment of tooth fragment, incisal edge or cusp	0	
D2929	Prefabricated porcelain/ceramic crown – primary tooth	NB	
D2930	Prefabricated stainless steel crown - primary tooth	0	
D2931	Prefabricated stainless steel crown - permanent tooth	0	
D2932	Prefabricated resin crown - anterior teeth only	15	
D2933	Prefabricated stainless steel crown with resin window	10	
D2940	Sedative filling	0	
D2941	Interim therapeutic restoration – primary dentition	0	
D2949	Restorative foundation for an indirect restoration	50	
D2950	Core build-up, including any pins	50	
D2951	Pin retention - per tooth, in addition to restoration	0	
D2952	Cast post and core in addition to crown	0	

Code	Description	Co-payment	Notes
D2953	Each additional indirectly fabricated post - same tooth	0	
D2954	Prefabricated post and core in addition to crown	0	
D2957	Each additional prefabricated post - same tooth	0	
D2970	Temporary crown (fractured tooth)	5	
D2971	Additional procedures to construct new crown under existing partial denture framework	19	
D2980	Crown repair necessitated by restorative material failure	10	
D2981	Inlay repair necessitated by restorative material failure	10	
D2982	Onlay repair necessitated by restorative material failure	10	
D2983	Veneer repair necessitated by restorative material failure	10	
	Endodontics D3000 - D3999		
D3110	Pulp cap-direct (excluding final restoration)	0	
D3120	Pulp cap-indirect (excluding final restoration)	0	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0	
D3221	Pulpal debridement, primary and permanent teeth	5	
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0	
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (exclude final restoration)	5	
D3240	Pulpal therapy (resorbable filling) posterior, primary tooth(exclude final restoration)	5	
D3310	Root canal - anterior (excluding final restoration)	45	
D3320	Root canal - bicuspid (excluding final restoration)	90	
D3330	Root canal - molar (excluding final restoration)	205	R
D3331	Treatment of root canal obstruction; non-surgical access	0	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	45	R
D3346	Retreatment of previous root canal therapy - anterior	60	R
D3347	Retreatment of previous root canal therapy - bicuspid	105	R
D3348	Retreatment of previous root canal therapy - molar	220	R
D3351	Apexification/recalcification – initial visit (apical closure/calcify repair of perforations, root resorption, etc)	70	R
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc)	45	R
D3353	Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc)	45	R
D3410	Apicoectomy/periradicular surgery - anterior	0	R
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	0	R
D3425	Apicoectomy/per. surgery molar (first root)	0	R
D3426	Apicoectomy/periradicular surgery (each additional root)	0	R
D3427	Pariradicular surgery without apicoectomy	0	R
D3428	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	195	R
D3429	Bone graft in conjunction with periradicular surgery – each additional contiguous tooth in the same surgical site	60	R
D3430	Retrograde filling - per root	50	R

Code	Description	Co-payment	Notes
D3450	Root Amputation - per root	0	R
D3910	Surgical procedure for isolation of tooth with rubber dam	0	
D3920	Hemisection (including any root removal), not including root canal therapy	0	R
D3950	Canal preparation and fitting of preformed dowel or post	0	
	Periodontics - D4000 - D4999		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	80	
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or bounded teeth spaces per quadrant	50	
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	50	
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant	80	R
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant	50	R
D4245	Apically positioned flap	75	R
D4249	Crown lengthening - hard/soft tissue	75	R
D4260	Osseous surgery (including elevation or a full thickness flap and closure) - four or more contiguous teeth or bounded teeth spaces per quadrant	175	R
D4261	Osseous surgery (including elevation or a full thickness flap and closure) - one to three teeth per quadrant	140	R
D4263	Bone replacement graph – first site in quadrant	195	R
D4264	Bone replacement graph – each additional site in quadrant	60	R
D4268	Surgical revision procedure, per tooth	0	
D4270	Pedicle soft tissue graft procedure	195	R
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	45	R
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	195	R
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	98	R
D4341	Periodontal root planing - four or more teeth per quadrant	0	
D4342	Periodontal root planing - one to three teeth per quadrant	0	
D4355	Full Mouth debridement to enable comprehensive evaluation and diagnosis	0	
D4910	Periodontal maintenance	0	
	Prosthodontics, removable D5000 - D5899		
D5110	Complete denture - maxillary	100	
D5120	Complete denture - mandibular	100	
D5130	Immediate denture – maxillary	120	
D5140	Immediate denture - mandibular	120	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	80	
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	80	
D5213	Maxillary partial denture - cast metal framework with resin	120	

Code	Description	Co-payment	Notes
	denture bases (including any conventional clasps, rests and teeth)		
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	120	
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	170	
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	170	
D5410	Adjust complete denture - maxillary	0	
D5411	Adjust complete denture - mandibular	0	
D5421	Adjust partial denture - maxillary	0	
D5422	Adjust partial denture - mandibular	0	
D5510	Repair broken complete denture base	15	
D5520	Replace missing or broken teeth - complete denture (each tooth)	5	
D5610	Repair resin denture base	15	
D5620	Repair cast framework	15	
D5630	Repair or replace broken clasp	15	
D5640	Replace broken teeth - per tooth	5	
D5650	Add tooth to existing partial denture	5	
D5660	Add clasp to existing partial denture	5	
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	75	
D5671	Replace teeth and acrylic on cast metal framework (mandibular)	75	
D5710	Rebase complete maxillary denture	35	
D5711	Rebase complete mandibular denture	35	
D5720	Rebase maxillary partial denture	35	
D5721	Rebase mandibular partial denture	35	
D5730	Reline complete maxillary denture (chairside)	0	
D5731	Reline complete mandibular denture (chairside)	0	
D5740	Reline maxillary partial denture (chairside)	0	
D5741	Reline mandibular partial denture (chairside)	0	
D5750	Reline complete maxillary denture (laboratory)	35	
D5751	Reline complete mandibular denture (laboratory)	35	
D5760	Reline maxillary partial denture (laboratory)	35	
D5761	Reline mandibular partial denture (laboratory)	35	
D5820	Interim partial denture (maxillary)	45	
D5821	Interim partial denture (mandibular)	45	
D5850	Tissue conditioning, maxillary	0	
D5851	Tissue conditioning, mandibular	0	
	VIII. Prosthodontics, Fixed D6200 - D6999		
D6010	Surgical placement of implant body: endosteal implant	NB	
D6012	Surg placement of intrm endosteal implant	NB	
D6051	Interim abutment	NB	
D6101	debridement of a periimplant defect or defects surrounding a single implant, and surface cleaning of the exposed implant surfaces, including flap entry and closure	NB	

Code	Description	Co-payment	Notes
D6102	debridement and osseous contouring of a periimplant defect; or defects surrounding a single implant, and surface cleaning includes surface cleaning of the exposed implant surfaces and ,including flap entry and closure	NB	
D6103	Bone graft for repair of periimplant defect – does not include flap entry and closure, placement of a barrier membrane or biologic materials to aid in osseous regeneration	NB	
D6210	Pontic - cast high noble metal	170	
D6211	Pontic - cast predominantly base metal	70	
D6212	Pontic - cast noble metal	110	
D6240	Pontic - porcelain fused to high noble metal	195	
D6241	Pontic - porcelain fused to predominantly base metal	95	
D6242	Pontic - porcelain fused to noble metal	135	
D6245	Pontic – porcelain/ceramic	195	
D6250	Pontic - resin with high noble metal	155	
D6251	Pontic - resin with predominantly base metal	55	
D6252	Pontic - resin with noble metal	95	
D6600	Inlay - porcelain/ceramic, two surfaces	150	
D6601	Inlay - porcelain/ceramic, three or more surfaces	160	
D6602	Inlay - cast high noble metal, two surfaces	100	
D6603	Inlay - cast high noble metal, three or more surfaces	100	
D6604	Inlay - cast predominantly base metal, two surfaces	0	
D6605	Inlay - cast predominantly base metal, three or more surfaces	0	
D6606	Inlay - cast noble metal, two surfaces	40	
D6607	Inlay - cast noble metal, three or more surfaces	40	
D6608	Onlay - porcelain/ceramic, two surfaces	150	
D6609	Onlay - porcelain/ceramic, three or more surfaces	165	
D6610	Onlay - cast high noble metal, two surfaces	100	
D6611	Onlay - cast high noble metal, three or more surfaces	100	
D6612	Onlay - cast predominantly base metal, two surfaces	0	
D6613	Onlay - cast predominantly base metal, three or more surfaces	0	
D6614	Onlay - cast noble metal, two surfaces	40	
D6615	Onlay - cast noble metal, three or more surfaces	40	
D6720	Retainer Crown - resin fused to high noble metal	155	
D6721	Retainer Crown - resin with predominantly base metal	55	
D6722	Retainer Crown - resin with noble metal	95	
D6740	Retainer Crown – porcelain/ceramic	195	
D6750	Retainer Crown - porcelain fused to high noble metal	195	
D6751	Retainer Crown - porcelain fused to predominantly base metal	95	
D6752	Retainer Crown - porcelain fused to noble metal	135	
D6780	Retainer Crown - 3/4 cast high noble metal	170	
D6781	Retainer Crown - 3/4 cast predominantly base metal	70	
D6782	Retainer Crown - 3/4 cast noble metal	110	
D6783	Retainer Crown - 3/4 porcelain/ceramic	195	
D6790	Retainer Crown - full cast high noble metal	170	
D6791	Retainer Crown - full cast predominantly base metal	70	

Code	Description	Co-payment	Notes
D6792	Retainer Crown - full cast noble metal	110	
D6930	Re-cement or re-bond fixed partial denture	0	
D6940	Stress breaker	0	
D6980	Fixed partial denture repair necessitated by restorative material failure	10	
	Oral Surgery D7000 - D7999		
D7111	Extraction, coronal remnants - deciduous tooth	0	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal); includes routine removal of tooth structure, minor smoothing of socket bone and closure, as necessary	0	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	15	
D7220	Removal of impacted tooth - soft tissue	25	R
D7230	Removal of impacted tooth - partially bony	50	R
D7240	Removal of impacted tooth - completely bony	70	R
D7241	Removal of impacted tooth-completely bony w/complications	90	R
D7250	Surgical removal of residual tooth roots	0	R
D7251	Coronectomy - intentional partial tooth removal	90	R
D7280	Surgical access of an unerupted tooth	85	R
D7283	Placement of device to facilitate eruption of impacted tooth	0	R
D7286	Incisional Biopsy of oral tissue, soft	0	R
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	0	
D7311	Alveoloplasty - in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces - per quadrant	0	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	0	
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	0	
D7471	Removal of lateral exostosis - (maxilla or mandible)	0	R
D7472	Removal of torus palatinus	0	R
D7473	Removal of torus mandibularis	0	R
D7510	Incision and drainage of abscess	0	R
D7952	Sinus augmentation via a vertical approach	NB	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	0	R
D7970	Excision hyperplastic tissue – per arch	50	R
D7971	Excision of pericoronal gingival	50	
	Additional Procedures D9000 - D9999		
D9110	Palliative (emergency) treatment of dental pain - minor procedure	5	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	0	
D9211	Regional block anesthesia	0	
D9212	Trigeminal division block anesthesia	0	

Code	Description	Co-payment	Notes
D9215	Local anesthesia	0	
D9219	Evaluation for deep sedation or general anesthesia	NB*	*Covered for children through age 6 or when medically necessary only
D9220	Deep sedation/General Anesthesia – first 30 minutes	165*	R *Covered for children through age 6 or when medically necessary only
D9221	Deep sedation/General Anesthesia each additional 15 minutes	165	R
D9241	Intravenous moderate (conscious) sedation/Analgesia – up to 30 minutes	80	R
D9242	Intravenous moderate (conscious) sedation/Analgesia – each additional 15 minutes	80	R
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	0	
D9430	Office visit for observation (during regular office hours) – on other services performed -	5	
D9440	Office visit - after regularly scheduled hours	20	
D9450	Case presentation, detailed and extensive treatment planning	0	
D9940	Occlusal guard, by report – limited to one in three years	95	
D9951	Occlusal adjustment, limited	20	
D9952	Occlusal adjustment, complete	40	
D9972	External bleaching – per arch - performed in office	125	
D9975	External bleaching for home application, per arch	125	
D0125	Failed Appointment without 24 hr notice per 15 min of appt time	10	
D9999	Unspecified adjunctive procedure, by report	10	

NB = Not a benefit

D8000 – D8999 XI. Orthodontic Procedures		**DeltaCare Standard Ortho Plan A**
D8660	Pre-orthodontic treatment examination to monitor growth and development	25
D8660	Records solely for the purpose of Orthodontics	200
D0210	Intraoral- complete series of radiographic images(including bitewings)	70
D0340	Cephalometric radiographic image	
D0330	Panoramic radiographic image	
D0322	Tomographic survey	
D0350	Oral/facial images (includes intra and extra oral images)	
D0470	Diagnostic casts	

D8000 – D8999 XI. Orthodontic Procedures		DeltaCare Standard Ortho Plan A
D8660 D0210 D0470	Post-records: Intraoral - complete series (including bitewings) Diagnostic casts *(co-payment is applied to treatment fee if patient proceeds with treatment)*	70
D8020 D8030	Limited orthodontic treatment	NB
D8070 D8080	Comprehensive orthodontic treatment transitional dentition (Comprehensive orthodontic treatment adolescent dentition)	1600
D8090	Comprehensive orthodontic treatment of the adult dentition	2000
D8670	Periodic orthodontic treatment visit (as part of contract-first 24 months)	Inclusive of total case fee
D8670	Periodic orthodontic treatment visit beyond 24 months	75
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	0

Claim Review and Appeal

Predetermination of Benefits

Covered dental benefits that which are prepaid to your Primary Care Provider are documented in the DeltaCare provider manual and the member's benefit booklet. These procedures do not require predetermination and are considered covered. If the treatment will be provided by a provider other than the assigned PCP, DDWA recommends, and will accept a request for a predetermination of benefits.

A predetermination is a request made by your PCP to DDWA to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A predetermination is not an authorization for services but a notification of Covered Dental Benefits available at the time the predetermination is made and is not a guarantee of payment (please refer to the “Initial Benefits Determination” section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete DDWA will notify you and your Dentist in writing that additional information is required in order to process the predetermination. Once the additional information is available your Dentist should submit a new request for a predetermination to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the predetermination is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, whereby a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, DDWA will review the request within 72-hours from receipt of the request and all supporting documentation. When practical, DDWA may provide notice of determination orally with written or electronic confirmation to follow within 72 hours.

Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to DDWA for payment, modification or denial of services. In accordance with regulatory requirements, DDWA processes all clean claims within 30 days from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims not meeting this definition are paid or denied within 60 days of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with a written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification
- Reference to the specific plan provision on which the determination was based
- Your appeal rights should you wish to dispute the original determination

Appeals of Denied Claims

How to contact us

DDWA will accept notice of an Urgent Care Request or Appeal if made by you, your covered dependent, or an authorized representative orally by contacting us at the telephone number below or in writing directed to Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983. You may include any written comments, documents or other information that you believe supports your claim. For more information please call 1-800-650-1583.

Authorized Representative

You may authorize another person to represent you or your child and receive communications from DDWA regarding your specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

Informal Review

If your claim for dental benefits has been completely or partially denied, you have the right to request an informal review of the decision. Either you, or your authorized representative (see above), must submit your request for a review within 180 days from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and include the following information:

- Your name and ID number
- The claim number (from your Explanation of Benefits form)
- The name of the dentist

DDWA will review your claim, make a determination within 14 days of receiving your request, and may take up to an additional 16 days with the delivery of this notice, for a total of 30 days. DDWA will send you a written notification of the review decision and information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

Formal Review

If you are dissatisfied with the outcome of the informal review, you may request in writing that your claim be reviewed formally by the DDWA Appeals Committee. This Committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within 90 days of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim and make a determination within 30 days of receiving your request, and send you a written notification of the review decision. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision.

Whenever DDWA makes an adverse determination and delay would jeopardize the eligible person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the eligible person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review consistent with applicable regulation.

Continuation of Coverage — "COBRA"

The "Continuation of Coverage" legislation passed into federal law (PL 99-272 and as amended by PL 104-191) requires that should certain qualifying events occur which would have previously terminated coverage, coverage may continue for a period of time on a self-pay basis.

When you terminate for reasons other than gross misconduct, you may continue your dental benefits up to 18 months, or until you are covered under another group dental plan, by self-paying the required premium.

If a dependent no longer meets the eligibility requirements due to the death or divorce of the employee, or does not meet the age requirement for children, coverage may continue up to three years, or until the dependent is covered under another group dental plan, by self-paying the required premium.

Contact your employer for further clarification and details of how they plan to implement this continuation of coverage for eligible persons.

Coordination of Benefits

Coordination of This Contract's Benefits with Other Benefits: The coordination of benefits (COB) provision applies when you have dental coverage under more than one *Plan*. *Plan* is defined below.

Note: This Plan will always be considered primary (the plan whose benefits are determined first), except under the following circumstances: 1) orthodontic benefits that are payable on a fee-for-service basis shall be based on the provisions of this section; 2) if both this Contract and the other Plan have provisions stating they are primary, then see the "*Order of Benefit Determination Rules*" below to establish the order of benefit payment under the Plans; 3) when required by an existing Health Care Responsibility (HCR) or other Court Order.

The order of benefit determination rules govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary Plan*. The *Primary Plan* must pay benefits according to its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary Plan* is the *Secondary Plan*. The *Secondary Plan* may reduce the benefits it pays so that payments from all *Plan*s do not exceed 100 percent of the total *Allowable Expense*.

Definitions: For the purpose of this section, the following definitions shall apply:

A "***Plan***" is any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same *Plan* and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate *Plan*.

- *Plan* includes: group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), *Closed Panel Plan*s or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental *Plan*, as permitted by law.

- *Plan* does not include: hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident and similar coverage that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; A state *plan* under Medicaid; A governmental *plan*, which, by law, provides benefits that are in excess of those of any private insurance *plan* or other nongovernmental *plan*; automobile insurance policies required by statute to provide medical benefits; benefits provided as part of a direct agreement with a direct patient-provider primary care practice as defined by law or coverage under other federal governmental *Plan*s, unless permitted by law.

Each contract for coverage under the above bullet points is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

"***This Plan***" means, in a COB provision, the part of the contract providing the dental benefits to which the COB provision applies and which may be reduced because of the benefits of other *Plan*s. Any other part of the contract providing dental benefits is separate from *This Plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether *This Plan* is a *Primary Plan* or *Secondary Plan* when you have dental coverage under more than one *Plan*.

When *This Plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan*'s benefits. When *This Plan* is secondary, it determines its benefits after those of another *Plan* and must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim are coordinated up to 100 percent of the total *Allowable Expense* for that claim. This means that when *This Plan* is secondary, it must pay the amount which, when combined with what the *Primary Plan* paid, does not exceed 100 percent of the highest *Allowable Expense*. In addition, if *This Plan* is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the *Primary Plan*) and record these savings as a benefit reserve for you. This reserve must be used to pay any expenses during that calendar year, whether or not they are an *Allowable Expense* under *This Plan*. If *This Plan* is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

"***Allowable Expense***", means any health care expense including coinsurance or co-payments and without reduction for any applicable deductible, that is covered in full or in part by any of the *plans* covering you. When coordinating benefits as the secondary plan, Delta Dental of Washington must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event will DDWA be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

An expense or a portion of an expense that is not covered by any of the *plan*s is not an allowable expense. The following are examples of expenses that are not *Allowable Expense*s:

- If you are covered by two or more *Plan*s that compute their benefit payments on the basis of a relative value schedule reimbursement method or other similar reimbursement method, any amount charged by the provider in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- If you are covered by two or more *Plan*s that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.

"***Closed Panel Plan***" is a *Plan* that provides dental benefits to you in the form of services through a panel of providers who are primarily employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

"***Custodial Parent***" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules: When you are covered by two or more *Plan*s, the rules for determining the order of benefit payments are as follows:

The *Primary Plan* must pay or provide its benefits as if the *Secondary Plan* or *Plans* did not exist.

A *Plan* that does not contain a coordination of benefits provision that is consistent with Chapter 284-51 of the Washington Administrative Code is always primary unless the provisions of both *Plan*s state that the complying *Plan* is primary, except coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the *Plan* provided by the contract holder.

A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

Each *Plan* determines its order of benefits using the first of the following rules that apply:

"***Non-Dependent or Dependent***:" The *Plan* that covers you other than as a *Dependent*, for example as an employee, member, policyholder, subscriber or retiree is the *Primary Plan* and the *Plan* that covers you as a *Dependent* is the *Secondary Plan*. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering you as a *Dependent*, and primary to the *Plan* covering you as other than a *Dependent* (e.g., a retired employee), then the order of benefits between the two *Plan*s is reversed so that the *Plan* covering you as an employee, member, policyholder, subscriber or retiree is the *Secondary Plan* and the other *Plan* is the *Primary Plan*.

"***Dependent Child Covered Under More Than One Plan:***" Unless there is a court decree stating otherwise, when a *Dependent* child is covered by more than one *Plan* the order of benefits is determined as follows:

1) For a *Dependent* child whose parents are married or are living together, whether or not they have ever been married:
   a) The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary Plan*; or
   b) If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary Plan*.
2) For a *Dependent* child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   a) If a court decree states that one of the parents is responsible for the Dependent child's dental expenses or dental coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to claims determination periods commencing after the *Plan* is given notice of the court decree;
   b) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for dental expenses, the *Plan* of the parent assuming financial responsibility is primary;
   c) If a court decree states that both parents are responsible for the Dependent child's dental expenses or dental coverage, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits;
   d) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the dental expenses or dental coverage of the Dependent child, the provisions of the first bullet point above (for dependent child(ren) whose parents are married or are living together) determine the order of benefits; or

e) If there is no court decree allocating responsibility for the Dependent child's dental expenses or dental coverage, the order of benefits for the child is as follows:
    I. The *Plan* covering the *Custodial Parent*, first;
    II. The *Plan* covering the spouse of the *Custodial Parent*, second;
    III. The *Plan* covering the non*custodial Parent*, third; and then
    IV. The *Plan* covering the spouse of the non*custodial Parent*, last

3) For a *Dependent* child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of the first or second bullet points above (for *dependent* child(ren) whose parents are married or are living together or for *dependent* child(ren) whose parents are divorced or separated or not living together) determine the order of benefits as if those individuals were the parents of the child.

"***Active Employee or Retired or Laid-off Employee:***" The *Plan* that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary Plan*. The *Plan* covering you as a retired or laid-off employee is the *Secondary Plan*. The same would hold true if you are a *Dependent* of an active employee and you are a *Dependent* of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***COBRA or State Continuation Coverage:***" If your coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering you as an employee, member, subscriber or retiree or covering you as a *Dependent* of an employee, member, subscriber or retiree is the *Primary Plan* and the COBRA or state or other federal continuation coverage is the *Secondary Plan*. If the other *Plan* does not have this rule, and as a result, the *Plan*s do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under the *Non-Dependent* or *Dependent* provision above can determine the order of benefits.

"***Longer or Shorter Length of Coverage:***" The *Plan* that covered you as an employee, member, policyholder, subscriber or retiree longer is the *Primary Plan* and the *Plan* that covered you the shorter period of time is the *Secondary Plan*.

If the preceding rules do not determine the order of benefits, the *Allowable Expense*s must be shared equally between the *Plan*s meeting the definition of *Plan*. In addition, *This Plan* will not pay more than it would have paid had it been the *Primary Plan*.

Effect on the Benefits of *This Plan*: When *This Plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plan*s during a claim determination period are not more than the *Total Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary Plan* must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *Plan*s for the claim do not exceed 100 percent of the total *Allowable Expense* for that claim. Total *Allowable Expense* is the highest *Allowable Expense* of the *Primary Plan* or the *Secondary Plan*. In addition, the *Secondary Plan* must credit to its *Plan* deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

How We Pay Claims When We Are Secondary: When we are knowingly the *Secondary Plan*, we will make payment promptly after receiving payment information from your *Primary Plan*. Your *Primary Plan*, and we as your *Secondary Plan*, may ask you and/or your provider for information in order to make payment. To expedite payment, be sure that you and/or your provider supply the information in a timely manner.

If the *Primary Plan* fails to pay within 60 calendar days of receiving all necessary information from you and your provider, you and/or your provider may submit your claim for us to make payment as if we were your *Primary Plan*. In such situations, we are required to pay claims within 30 calendar days of receiving your claim and the notice that your *Primary Plan* has not paid. This provision does not apply if Medicare is the *Primary Plan*. We may recover from the *Primary Plan* any excess amount paid under the "right of recovery" provision in the *plan*.

- If there is a difference between the amounts the *plan*s allow, we will base our payment on the higher amount. However, if the *Primary Plan* has a contract with the provider, our combined payments will not be more than the amount called for in our contract or the amount called for in the contract of the *Primary Plan*, whichever is higher. Health maintenance organizations (HMOs) and health care service contractors usually have contracts with their providers as do some other *plan*s.
- We will determine our payment by subtracting the amount paid by the *Primary Plan* from the amount we would have paid if we had been primary. We must make payment in an amount so that, when combined with the amount paid by the *Primary Plan*, the total benefits paid or provided by all *plan*s for the claim does not exceed one hundred percent of the total allowable expense (the highest of the amounts allowed under each *plan* involved) for your claim. We are not required to pay an amount in excess of our maximum benefit plus any accrued savings. If your provider negotiates reimbursement amounts with the *plan*(s) for the service provided, your provider may not bill you for any excess amounts once he/she has received payment for the highest of the negotiated amounts. When our deductible is fully credited, we will place any remaining amounts in a savings account to cover future claims which might not otherwise have been paid.

Right to Receive and Release Needed Information: Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under *This Plan* and other *Plan*s. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This Plan* and other *Plan*s covering you. The Company need not tell, or get the consent of, any person to do this. To claim benefits under *This Plan* you must give the Company any facts it needs to apply those rules and determine benefits payable.

Facility of Payment: If payments that should have been made under *This Plan* are made by another *Plan*, the Company has the right, at its discretion, to remit to the other *Plan* the amount the Company determines appropriate to satisfy the intent of this provision. The amounts paid to the other *Plan* are considered benefits paid under *This Plan*. To the extent of such payments, the Company is fully discharged from liability under *This Plan*.

Right of Recovery: DDWA has the right to recover excess payment whenever it has paid *Allowable Expense*s in excess of the maximum amount of payment necessary to satisfy the intent of this provision. WWDA may recover excess payment from any person to whom or for whom payment was made or any other Company or *Plan*s.

If payments that should have been made under *This Plan* are made by another *Plan*, DDWA has the right, at its discretion, to remit to the other *Plan* the amount it determines appropriate. To the extent of such payments, DDWA is fully discharged from liability under *This Plan*.

Notice to covered persons If you are covered by more than one health benefit *Plan*, and you do not know which is your *Primary Plan*, you or your provider should contact any one of the health *Plan*s to verify which *Plan* is primary. The health *Plan* you contact is responsible for working with the other health *Plan* to determine which is primary and will let you know within 30 calendar days.

CAUTION: All health *Plan*s have timely claim filing requirements. If you, or your provider, fail to submit your claim to a secondary health *Plan* within the *Plan*'s claim filing time limit, the *Plan* can deny the claim. If you experience delays in the processing of your claim by the primary health *Plan*, you or your provider will need to submit your claim to the secondary health *Plan* within its claim filing time limit to prevent a denial of the claim.

To avoid delays in claims processing, if you are covered by more than one *Plan* you should promptly report to your providers and *Plan*s any changes in your coverage.

Subrogation

If we pay benefits under this policy, and you are paid by someone else for the same procedures we pay for, we have the right to recover what we paid from the excess received by you, after full compensation for your loss is received. Any legal fees for recovery will be pro-rated between the parties based on the percentage of the recovery received. You have to sign and deliver to us any documents relating to the recovery that we reasonably request.

Subscriber Rights and Responsibilities

At Delta Dental of Washington our mission is to provide quality dental benefit products to employers and employees throughout Washington through the largest network of participating dentists in the state of Washington. We view our benefit packages as a partnership between Delta Dental of Washington, our subscribers and our participating member dentists. All partners in this process play an important role in achieving quality oral health services. We would like to take a moment and share our views of the rights and responsibilities that make this partnership work.

You have the right to:

- Seek care from any licensed dentist in Washington or nationally. Our reimbursement for such care varies depending on your choice (Delta Dental member / non-member), but you can receive care from any dentist you choose.
- Participate in decisions about your oral health care.
- Be informed about the oral health options available to you and your family.
- Request information concerning benefit coverage levels for proposed treatments prior to receiving services.
- Have access to specialists when services are required to complete a treatment, diagnosis or when your PCP makes a specific referral for specialty care.
- Contact Delta Dental of Washington customer service personnel during established business hours to ask questions about your oral health benefits. Alternatively, information is available on our website at deltadentalwa.com
- Appeal orally or in writing, decisions or requests regarding your dental benefit coverage. You should expect to have these issues resolved in a timely, professional and fair manner.
- Have your individual health information kept confidential and used only for resolving health care decisions or claims.
- Receive quality care regardless of your gender, race, sexual orientation, marital status, cultural, economic, educational or religious background.

To receive the best oral health care possible, it is your responsibility to:

- Know your benefit coverage and how it works.
- Arrive at the dental office on time or let the dental office know well in advance if you are unable to keep a scheduled appointment. Some offices require 24 hours notice for appointment cancellations before they will waive service charges.
- Ask questions about treatment options that are available to you regardless of coverage levels or cost.
- Give accurate and complete information about your health status and history and the health status and history of your family to all care providers when necessary.
- Read carefully and ask questions about all forms and documents which you are requested to sign, and request further information about items you do not understand.
- Follow instructions given by your dentist or their staff concerning daily oral health improvement or post-service care.
- Send requested documentation to Delta Dental of Washington to assist with the processing of claims, predeterminations or appeals.

- If applicable, pay the dental office the appropriate co-payments amount at time of visit.
- Respect the rights, office policies and property of each dental office you have the opportunity to visit.

Inform your dentist and your employer promptly of any change to your or a family member's address, telephone, or family status.

Glossary

Alveolar — Pertaining to the ridge, crest or process of bone which projects from the upper and lower jaw and supports the roots of the teeth.

Appeal — An oral or written communication by a subscriber requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits.

Bitewing X-ray — An x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.

Caries — Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Complaint — An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

Covered Dental Benefit - Those dental services which are covered under this plan, subject to the limitations set forth in Benefits Covered By Your Plan.

Crown — A restoration that replaces the entire surface of the visible portion of tooth.

Emergency Dental Condition — The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a dental condition exists that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Emergency Examination — Otherwise covered dental care services medically necessary to evaluate and treat an Emergency Dental Condition.

Endodontics — That branch of dentistry which deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

Exclusions — Dental services which are not a contract benefit set forth in Benefit Covered By Your Plan and all other services not specifically included as a Covered Dental Benefit set forth in Benefit Covered By Your Plan.

Fluoride — A substance when topically applied or applied to drinking water is effective in resisting tooth decay.

General Anesthesia — A drug or gas which produces unconsciousness and insensibility to pain.

Implant — A graft or insert set firmly onto or deeply into the alveolar area prepared for its insertion. It may support a crown or crowns, a bridge abutment, a partial denture or a complete denture.

Inlay — A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intravenous (I.V.) Sedation — A form of sedation whereby the patient experiences a lowered level of consciousness, but is still awake and can respond.

Licensed Professional — means an individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to, denturist, hygienist and radiology technician.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured. Dental services which are subject to restricting conditions set forth in Benefits Covered By Your Plan.

Localized delivery of antimicrobial agents — Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Occlusal Adjustment — Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard — A removable dental appliance — sometimes called a nightguard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (nightguard) is typically used at night.

Open Enrollment Period — The annual period in which subscribers can select benefits plans and add or delete eligible dependents.

Palliative Treatment — Services provided for emergency relief of dental pain.

Primary Care Dentist or Primary Care Provider (PCP)— The primary care dentist selected upon enrollment in the DeltaCare plan provides all necessary dental care and referrals.

Panorex X-ray — An x-ray system using two points of rotation to obtain a panoramic view of the dental arches.

Periodontics — That branch of dentistry which deals with the prevention and treatment of diseases of the bone and soft tissues surrounding the teeth.

Prophylaxis — The control of dental and oral diseases by preventive measures, especially the mechanical cleansing of the teeth.

Prosthodontics — That branch of dentistry which deals with the replacement of missing teeth or oral tissues by artificial means, such as crowns, bridges and dentures.

Restorative — A process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, crown, bridge or denture designed to restore proper dental function.

Root Planing — A procedure done to smooth roughened root surfaces.

Sealants — A resinous material designed for application to the surfaces of posterior teeth in order to seal the surface irregularities and prevent tooth decay.

Temporomandibular Joints — The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

DDWA, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today we cover more than 50 million people nationwide through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Advancing better oral health — that is what we are all about!

To learn more about DDWA and your benefits, visit our Web site at www.DeltaDentalWA.com.